Better Start Bradford Innovation Hub

HENRY
Final Report
December 2024

This is a report provided by the Better Start Bradford Innovation Hub (BSBIH) for Better Start Bradford and HENRY. The document provides an overview of HENRY's performance and findings from the implementation evaluation including an interpretation of these findings by BSBIH. The design of this evaluation is described in more detail in the Evaluation Plan Summary, which was approved by key stakeholders from the BSBIH and BSB.

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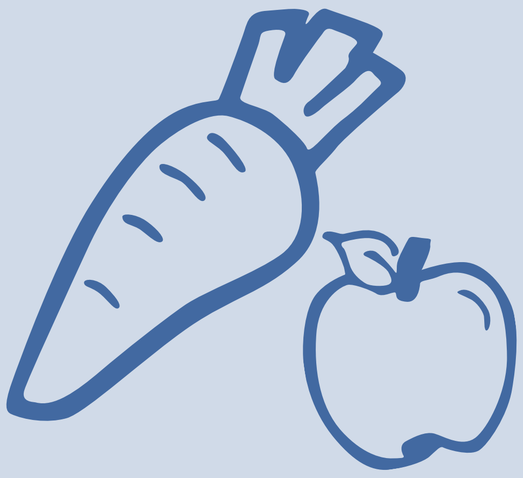
Approved by: Sara Ahern, BSBIH Programme Manager



Produced for Better Start Bradford

Better Start Bradford Innovation Hub

HENRY Final Report

December 2024

Executive Summary

Project Background

Obesity and overweight are large and growing public health issues, and increasing numbers of children are living with these conditions. In the UK, 20% of children are already living with overweight or obesity by the time they enter their Reception year of primary school, and this figure rises to 25% of children leaving primary school after year 6. Evidence has also revealed that poor diets that contribute to the risk of overweight and obesity can start early, and many children are exposed to foods high in sugar, fat, and salt from a very young age. It is vital that parents themselves have sufficient resources to model healthy practices and provide appropriate meals for their young children.

HENRY (Health, Exercise, Nutrition for the Really Young) is an evidence-based intervention commissioned as part of the original '*Eat, Live, Love*' workstream of Better Start Bradford. It aims to provide support to parents and carers of young children in order to improve their healthy eating habits and nutrition, with an eventual aim of decreasing the prevalence of childhood overweight and obesity within the Better Start Bradford area. The intervention consists of both training for practitioners and programmes for parents. This report describes findings from the BSBIH's evaluation of HENRY using project data collected between January 2016 and September 2024.

Evaluation Aims

Three evaluations were planned for the BSB HENRY project; an implementation evaluation, a before and after evaluation, and an effectiveness evaluation. The implementation evaluation aimed to understand whether the implementation of the project was in line with the logic model and delivery plan. The before and after evaluation considered the parents who attended both the group and 1:1 programme reported increases in parenting efficacy and healthier family behaviours at the end of their involvement with the programme as compared to at the beginning. This was done using the outcome questionnaires that are collected as a standard part of the HENRY programme. The effectiveness evaluation is still in development.

Key Findings

Recruitment

Overall, 1250 families were referred into the project. There was a shifting pattern of referral sources over time, but health visitors and self referrals always featured in the top five referral sources.

The project enrolled a total of 1135 carers onto the Group programme, which is 80% of the total target, putting them in **AMBER** for this criteria. A total of 139 carers enrolled onto the 1:1 programme, 63% of the target, putting the project in **RED** for this criteria. However, overall 98% of referrals went on to enroll in the project, which represents a very high referral to enrollee conversion rate.

Additionally, 75% of Group enrollees became participants, and 74% of Group participants completed the project. For the 1:1 project, 83% of enrollees became participants, and 77% of 1:1 participants completed the project. These high completion figures suggest strong engagement and high levels participant satisfaction.

80%

of group enrolment target

63%

of 1:1 enrolment target

Implementation

The project target for the number of Group programmes delivered in total was 148 . Overall, the project delivered 113 programmes, which was 76% of the target, putting them in **AMBER** for this progression criteria.

76%

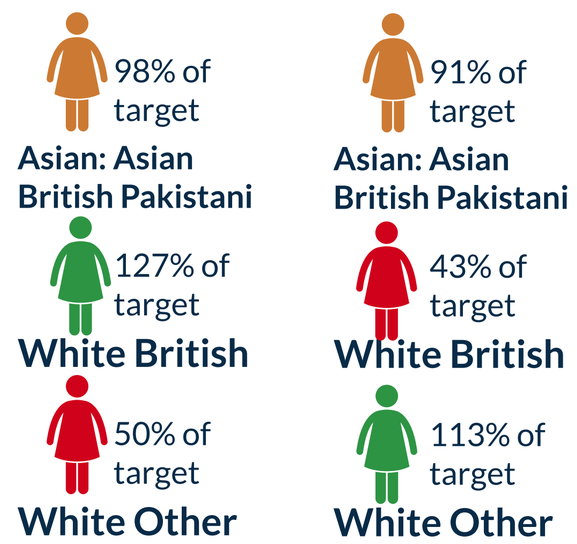
of the target number of Group programmes were delivered

Executive Summary

Key Findings

Reach

Reach progression criteria for the project set the target to recruit a representative sample of families for both the Group and 1:1 delivery of the service. While the project recruited a representative proportion of families from Asian: Asian British Pakistani backgrounds to both delivery formats, White British families were somewhat over-represented in the Group delivery, while White Other families were over-represented in the 1:1 delivery. However, alongside the demographic data on families' primary languages, this ethnicity data suggests that the Group and 1:1 versions of the project were serving different groups of the eligible population, and the 1:1 service made the project accessible to families who may have struggled to attend Group sessions.



Before and After results

Across both group and 1:1 programmes, statistically significant improvements in parental confidence were reported by carers at the end of a programme. Mealtime habits had also improved at the end of both programmes, specifically families were sitting down to eat together more frequently and had the tv on during meals less frequently. Significant increases in fruit and vegetable consumption were reported for carers and children as well as significant reductions in consumption of high fat and sugary snacks across both programmes. Physical activity habits had improved for both carers and children, with screen time reported as less frquent at the end of both programmes. While these results don't tell us about effectiveness of the programme, they suggest participation in HENRY can lead to changes in confidence and behaviour.

Recommendations

Recommendations for practice

- Continue to explore options for how this service could be delivered in the district. It is worth considering how a holistic service could be implemented that supports families to develop healthy feeding and eating habits right from when children begin weaning.
- If the project were to continue, it would be useful to carefully consider the referrals pathways, and how this could be supported in the absence of BSB.
- The 1:1 version of the project engages families who would struggle with group delivery, and should be kept in future.
- Consider whether training and other supports for childcare settings would be possible. Further training and support could be beneficial for children's wider environments.

Recommendations for evaluation

- The relatively consistent delivery of HENRY in the BSB area over the past nine years represents a unique opportunity to explore the impact of this service using routine data. The data reported here is encouraging and suggests that an effectiveness evaluation of the BSB HENRY service will be possible in the future. The overall aim of the evaluation would be to consider whether BiBBS children whose parents attended HENRY had significantly lower body mass indexes (BMIs) at ages 2 or 5 years, as compared to similar children who did not attend the project. The BSBIH's recommendation is that this evaluation move forward. However, it should be noted this evaluation will not be available until approximately 2028 .

Project background

About HENRY

Obesity and overweight are large and growing public health issues, and increasing numbers of children are living with these conditions. In the UK, 20% of children are already living with overweight or obesity by the time they enter their Reception year of primary school, and this figure rises to 25% of children leaving primary school after year 6 (ref). These increasing rates of overweight and obesity are also associated with increases in comorbidities including diabetes, liver disease, and sleep apnea (Kansra, Lakkunarajah, & Jay, 2021). Figures suggest that obesity and overweight rates for children growing up in the most deprived areas are twice those of children living in the least deprived areas (ref). There are also ethnic disparities, and obesity and overweight rates for children in year 6 are highest among those children from Bangladeshi, Pakistani, and Black backgrounds (ref).

Evidence has also revealed that poor diets that contribute to the risk of overweight and obesity can start early, and many children are exposed to foods high in sugar, fat, and salt from a very young age. In addition to the importance of adequate nutrition during children's very formative early years for their brain development and growth, early childhood is also a key time for learning positive food associations and habits (Lutter et al., 2021). As such, it is vital that parents themselves have sufficient resources to model healthy practices and provide appropriate meals for their young children.

HENRY (Health, Exercise, Nutrition for the Really Young) is an evidence-based intervention commissioned as part of the original '*Eat, Live, Love*' workstream of Better Start Bradford. It aims to provide support to parents and carers of young children in order to improve their healthy eating habits and nutrition, with an eventual aim of decreasing the prevalence of childhood overweight and obesity within the Better Start Bradford area. The intervention consists of both training for practitioners and programmes for parents.

Training offers:
- *Core Skills Training* aimed at health and early years professionals
- *Healthy Start in Childcare Training* for early years settings to complement existing food policies
- *Group Facilitation Skills Training* for those wishing to deliver the parent programmes

Offers for parents:
- *HENRY: Healthy Families Right From the Start* - an 8-week group programme to support healthy eating at home
- 1:1 delivery of the *HENRY: Healthy Families Right from the Start programme* - an individually delivered version of the group programme for those who would otherwise struggle to access the intervention
- '*Healthy Families*' workshops - targeted at specific groups

Aims of the evaluation

Three evaluations were planned for the BSB HENRY project; an implementation evaluation, a before and after evaluation, and an effectiveness evaluation. The implementation evaluation aimed to understand whether the implementation of the project was in line with the logic model and delivery plan. Particularly, it aimed to explore recruitment, reach, attendance, acceptability and satisfaction with the service. This was done by considering the monitoring data that was collected by the project throughout the contracts, and was considered for the group and 1:1 delivery of the project individually. The before and after evaluation considered the parents who attended both the group and 1:1 programme reported increases in parenting efficacy and healthier family behaviours at the end of their involvement with the programme as compared to at the beginning. This was done using the outcome questionnaires that are collected as a standard part of the HENRY programme.

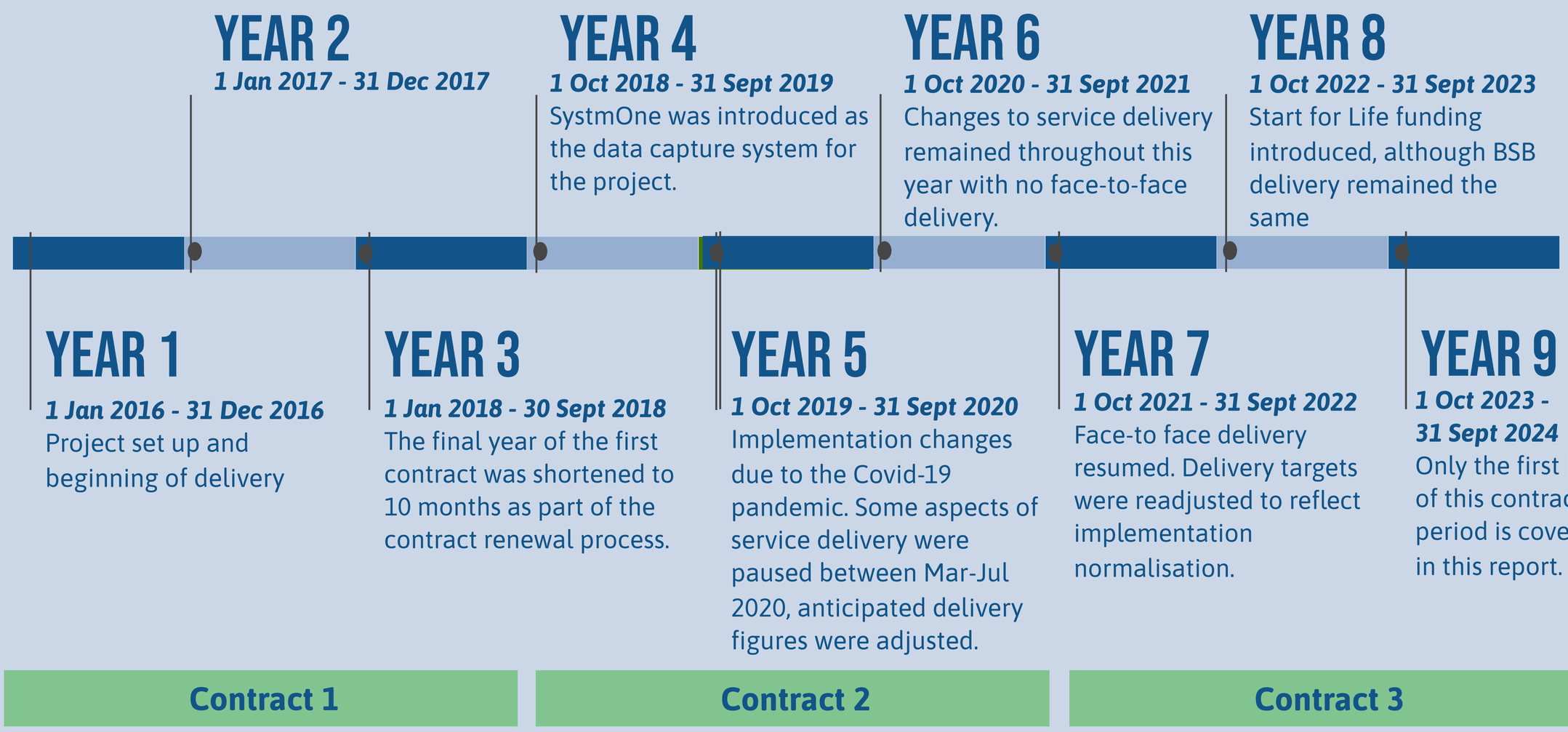
The effectiveness evaluation plans to consider whether children whose parents or carers attended the HENRY programme have a healthier BMI at ages 2 and/or 5 years old as compared to similar children whose carers did not take part in the project. This evaluation is still being developed, and many of the children who would be involved are not 5 years old yet.

Project background

The Impact of COVID-19

In response to the Covid-19 safety restrictions, the project was forced to change it's standard delivery model. All delivery of Group and 1:1 programmes was moved online using video conferencing. Targets were adjusted down to allow the project time to adapt the service to these new delivery models, and Group, 1:1, and training targets were amended during the fifth year of the contract. Both years 5 and 6 were significantly impacted by these implementation changes, and standard face-to-face delivery of courses did not resume until the beginning of year 7, and some online delivery continued beyond this point.

Figure 1. Timing and details of project delivery across the nine contract years



Data quality

The project has worked hard over the course of the three contract periods to provide accurate and timely data. However, a number of challenges have impacted on the project's data quality, including moving onto SystmOne after project initiation and high staff turnover. These challenges and others have at times resulted in data being inconsistent or unclear, and this has required both the project and the BSBIH to spend large amounts of time dealing with discrepancies. However, over the most recent contract period the project has worked particularly hard to work collaboratively with the BSBIH to ensure adequate data capture procedures that support data accuracy. Overall, the BSBIH's rating of data quality for the project is **AMBER**.

Despite these issues, the BSBIH is confident that the data reported here provides as complete and accurate a picture of the project's performance as is possible.

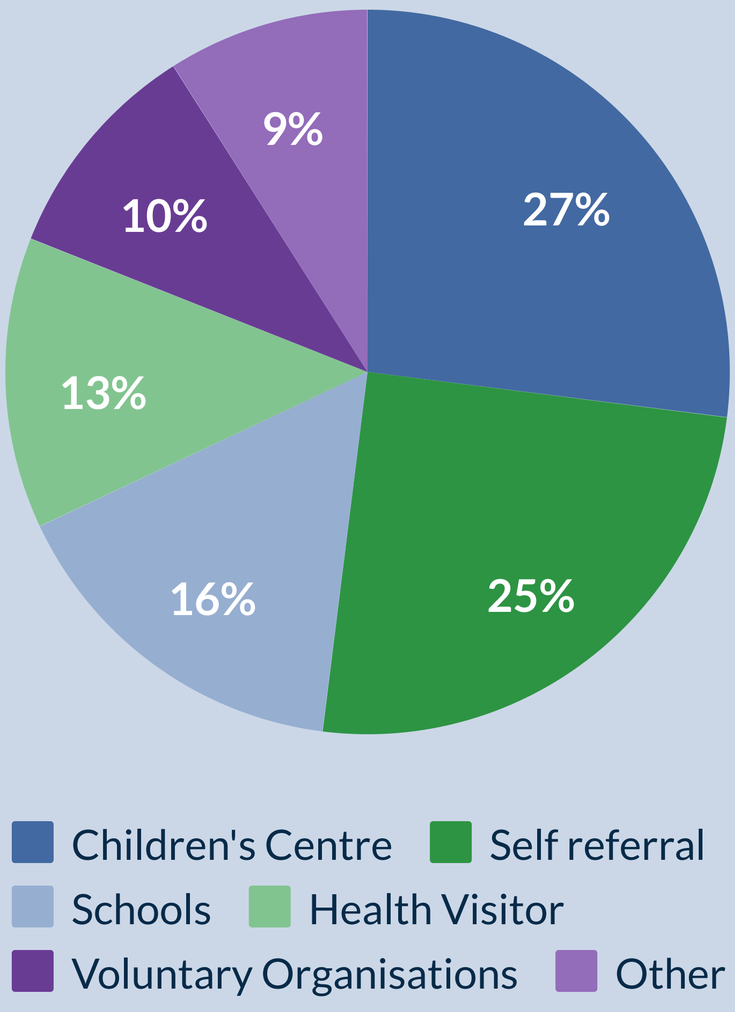
Evaluation Findings

Implementation Evaluation

How did families access HENRY?

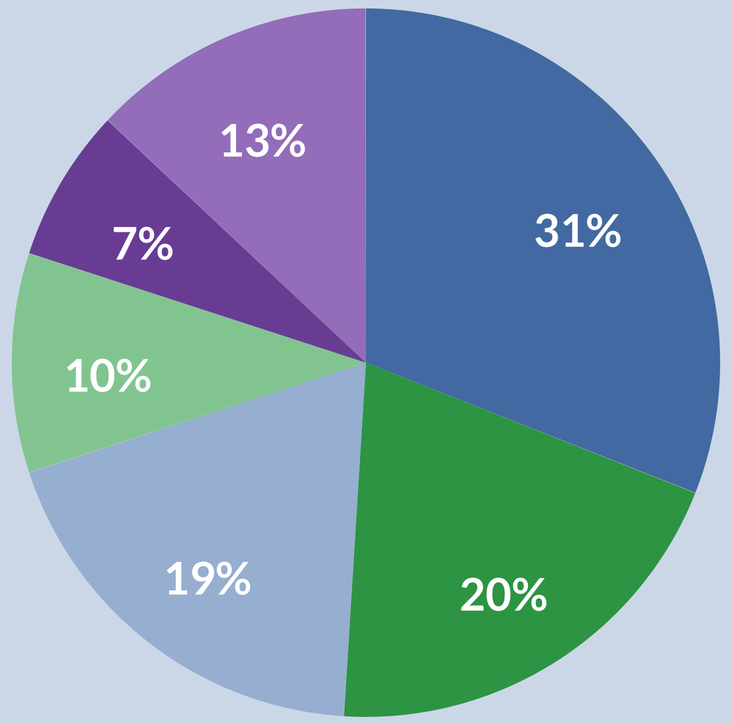
Where did referrals come from?

Figure 2. Contract 1 referral source



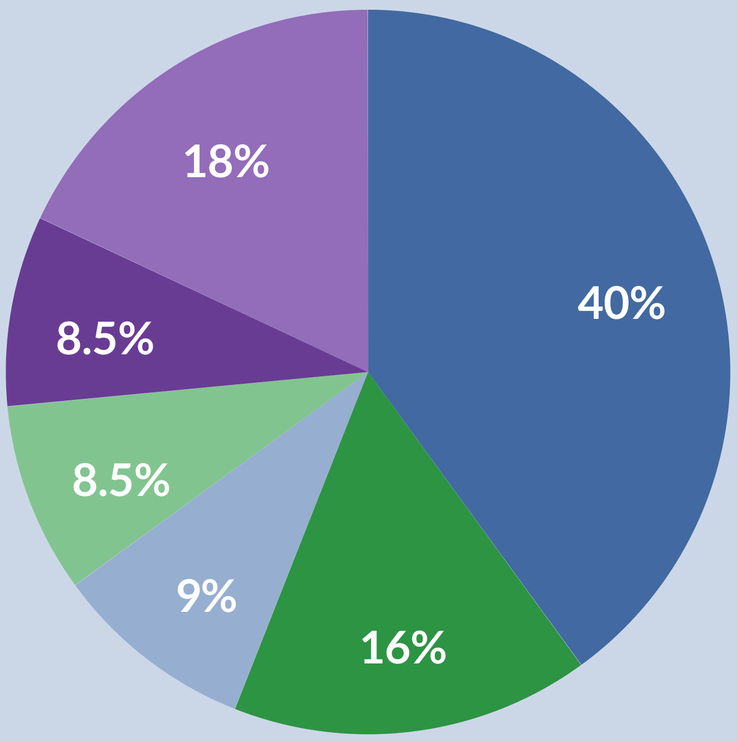
During the first contract, the largest referral source was children's centres (27%), reflecting the role of children centres in delivery at that time.
The second most common referral type was self referral (25%). Schools and health visitors also frequently referred into the project (15% and 13% of referrals respectively). Voluntary organisations accounted for 10% of referrals, while the remaining 9% of referrals came from other sources.

Figure 3. Contract 2 referral source



In the second contract, the majority of referrals came from health visitors (20%) and other professionals (31%). Self referrals accounted for 19% of all referrals, and 10% of referrals came from other BSB projects. Children's centers were responsible for 7% of referrals, while the remaining 14% of referrals came from other sources.

Figure 4. Contract 3 referral source



During the final contract, the BSB Face Team accounted for the largest proportion of referrals into the project (40%). Once again health visitors were an important source of referrals (16%), as were other BSB projects (9%). Self referrals accounted for 8% of all referrals, 8% of referrals came from other professionals, and the remaining 18% of referrals were from other sources.

Overall this shows a shifting pattern of referral sources that changed considerably over time. While health visitors and self referrals always featured in the top five referral sources for the project, children's centres, schools, and other professionals contributed proportionally fewer referrals over time. Conversely, the BSB Face Team and BSB projects became increasing sources of referrals by the third contract.

Evaluation Findings

Implementation Evaluation

Were families enrolled onto the programme?

Enrollment in HENRY was defined as when a family was contacted by the HENRY team and booked onto either the Group or 1:1 programme. For each year of project delivery, enrollment was the recruitment progression criteria, but enrollment targets changed over time. Annual target figures are shown in Table 1.

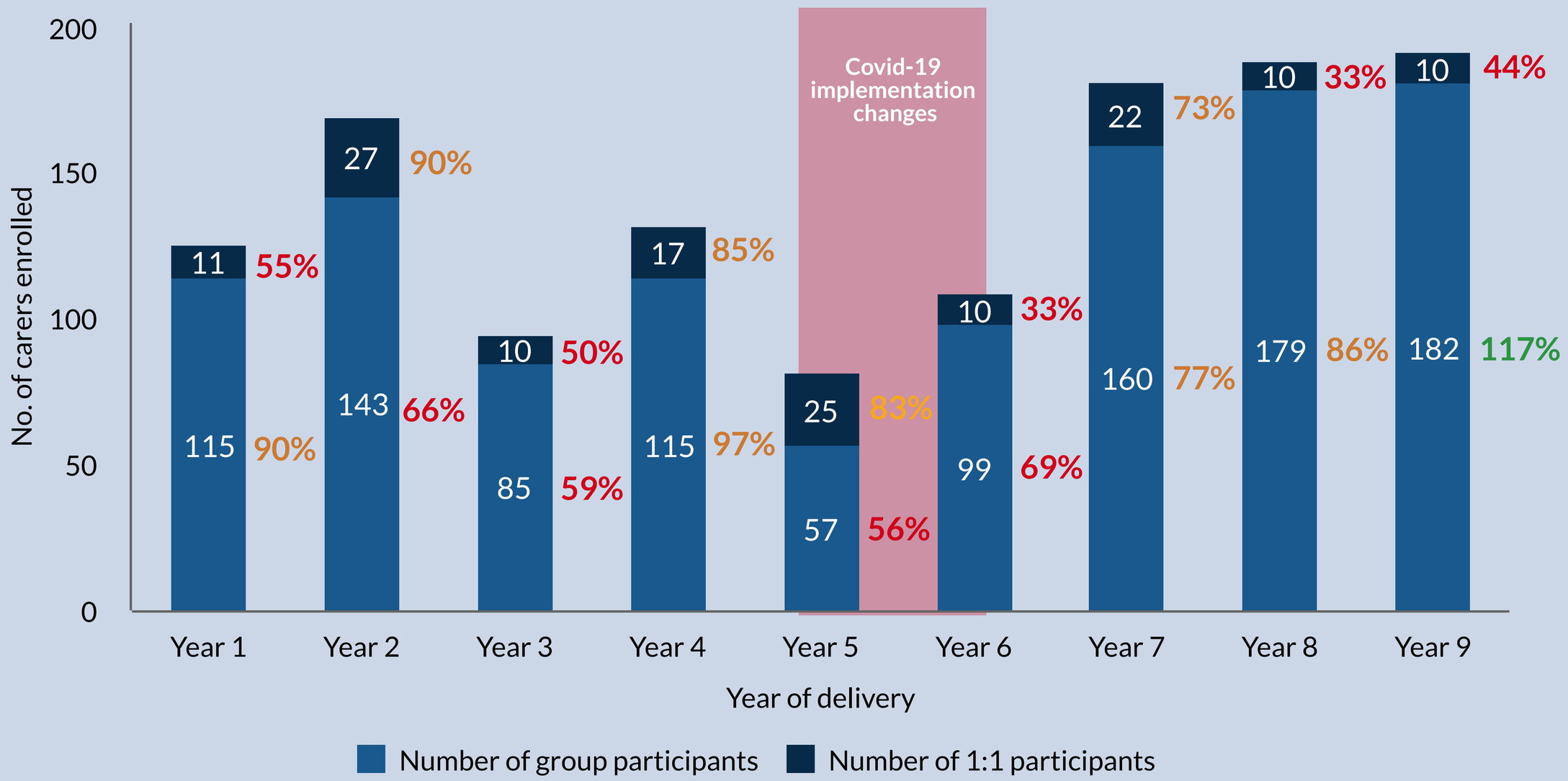
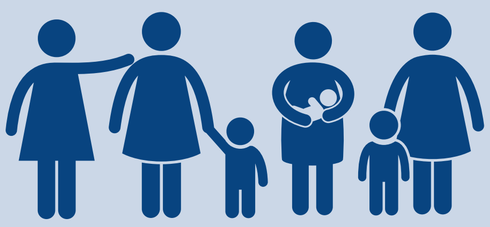


Figure 5. Annual enrollment numbers and proportions of target figures

Table 1. Annual enrollment targets for the HENRY Group and 1:1 programmes

	Group target	1:1 target
Y1	128	20
Y2	216	30
Y3	144	20
Y4	119	20
Y5	101	30
Y6	144	30
Y7	207	30
Y8	207	30
Y9	155	23



For the Group programme, in the first year of delivery 115 carers enrolled (90% of target), and this increased to 143 carers in the second year (66% of target). In the 10 months of year 3, 85 carers enrolled (59% of target), and in year 4 115 carers enrolled (97% of target). Years 5 and 6 were impacted by Covid-19, and 57 carers enrolled in year 5 (56% of adjusted target) and 99 carers in year 6 (69% of target). In year 7 160 carers enrolled (77% of target), 179 carers in year 8 (86% of target), and 182 carers in year 9 (117% of adjusted target).

80%

of Group enrollment target

For the 1:1 programme, targets were more consistently either 20 or 30 families. In year 1, 11 carers enrolled (55% of target), 27 enrolled in year 2 (29% of target), and 10 enrolled in year 3 (50% of target). In year 4 17 carers enrolled (85% of target), 25 carers enrolled in year 5 (83% of target), and 10 carers enrolled in year 6 (33% of target). Finally, 22 carers enrolled in year 7 (73% of target), 10 carers enrolled in year 8 (33% of target), and 10 enrolled in year 9 (44% of adjusted target).

60%

of 1:1 enrollment target

Overall, this means the project enrolled a total of 1135 carers onto the Group programme, which is 80% of the total target, putting them in **AMBER** for this criteria. A total of 139 carers enrolled onto the 1:1 programme, 60% of the target, putting the project in **RED** for this criteria.

Evaluation Findings

Implementation Evaluation

Did families attend and complete Group programmes?

Participation in HENRY was defined as when a family attended at least one session of either the Group or 1:1 programme. Over the nine years of delivery, a total of 852 parents and caregivers took part in the group programme. Details of home many parents and caregivers participated annually can be seen in Figure 6.

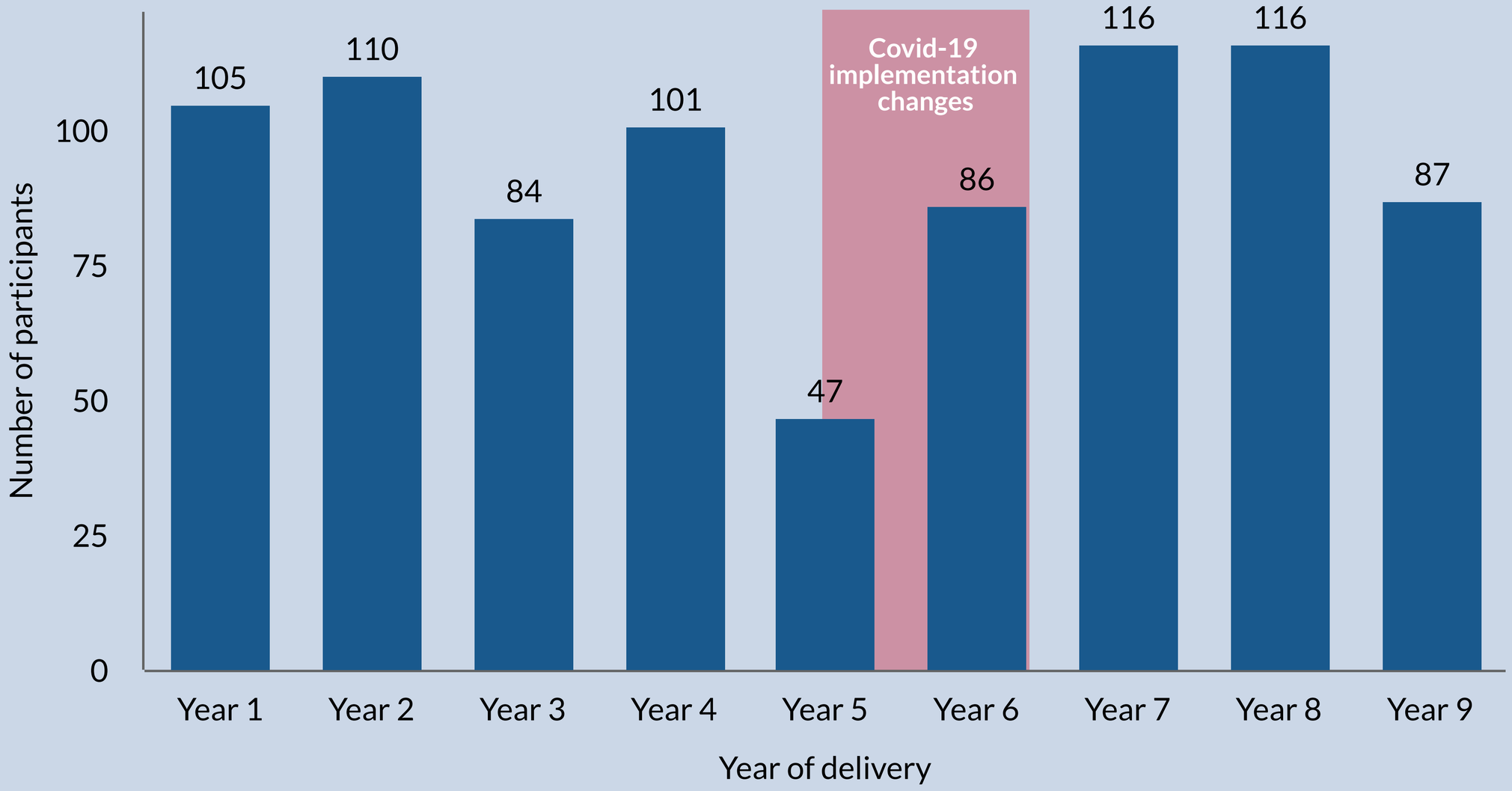


Figure 6. Annual number of parents and carers who participated in the Group programme

These figures show that 75% of parents and carers who enrolled onto the programme went on to participate.

75%

of group enrollees became participants

Group Completion

Completion of the project was defined as attending at least 5 of the 8 sessions. Anticipated numbers were based on 75% of participants going on to complete. Overall, 626 families completed the Group programme, which represents 74% of all participants, very close to target. Rates of completion varied year on year, but most years were above 70% which demonstrated high levels of completion of the programmw,

74%

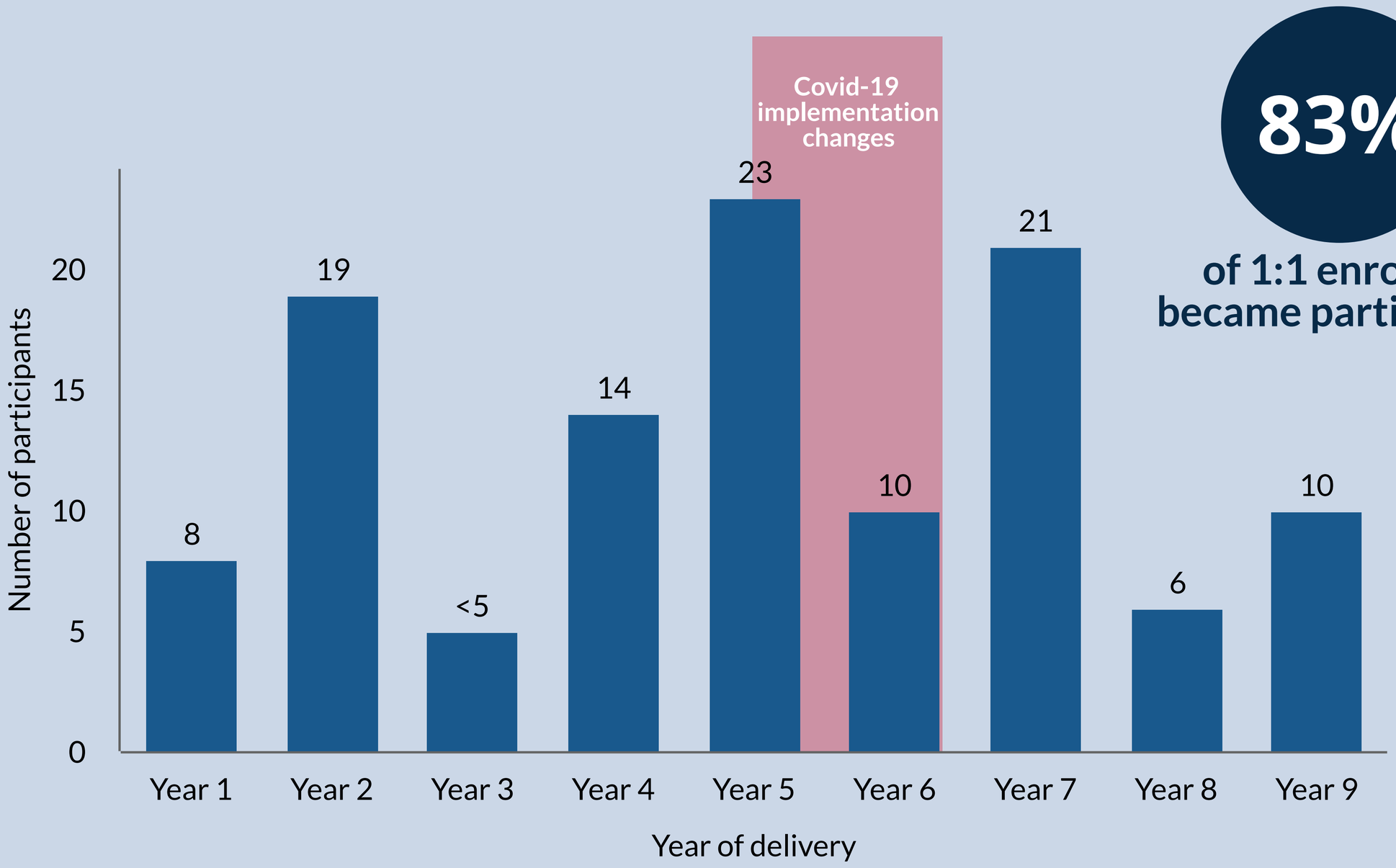
of participants completed a Group programme

Evaluation Findings

Implementation Evaluation

Did families attend and complete 1:1 programmes?

Over the course of the project, 139 parents and caregivers attended at least one session of the 1:1 programme. There was considerable variability in the number of families who participated in the 1:1 programme annually, as shown in Figure 8. However, the figures showed good engagement with families who enrolled onto the project as overall 83% of enrollees went on to participate in the project. Interestingly, participation in the 1:1 project was particularly strong during the years affected by Covid-19 (years 5 and 6), when 94% of enrollees went on to participate in the project.



83%

of 1:1 enrollees became participants

Figure 8. Annual number of parents and carers who participated in the 1:1 programme

1:1 Completion

Completion of the 1:1 delivery of the project was the same as for the Group programme, attendance at 5 of the 8 sessions. Over the three contracts, 77% of all 1:1 participants completed the programme. This shows a strong level of engagement with the project.

77%

of 1:1 participants completed the programme

Participant Flow Diagram

Group / 1:1 delivery

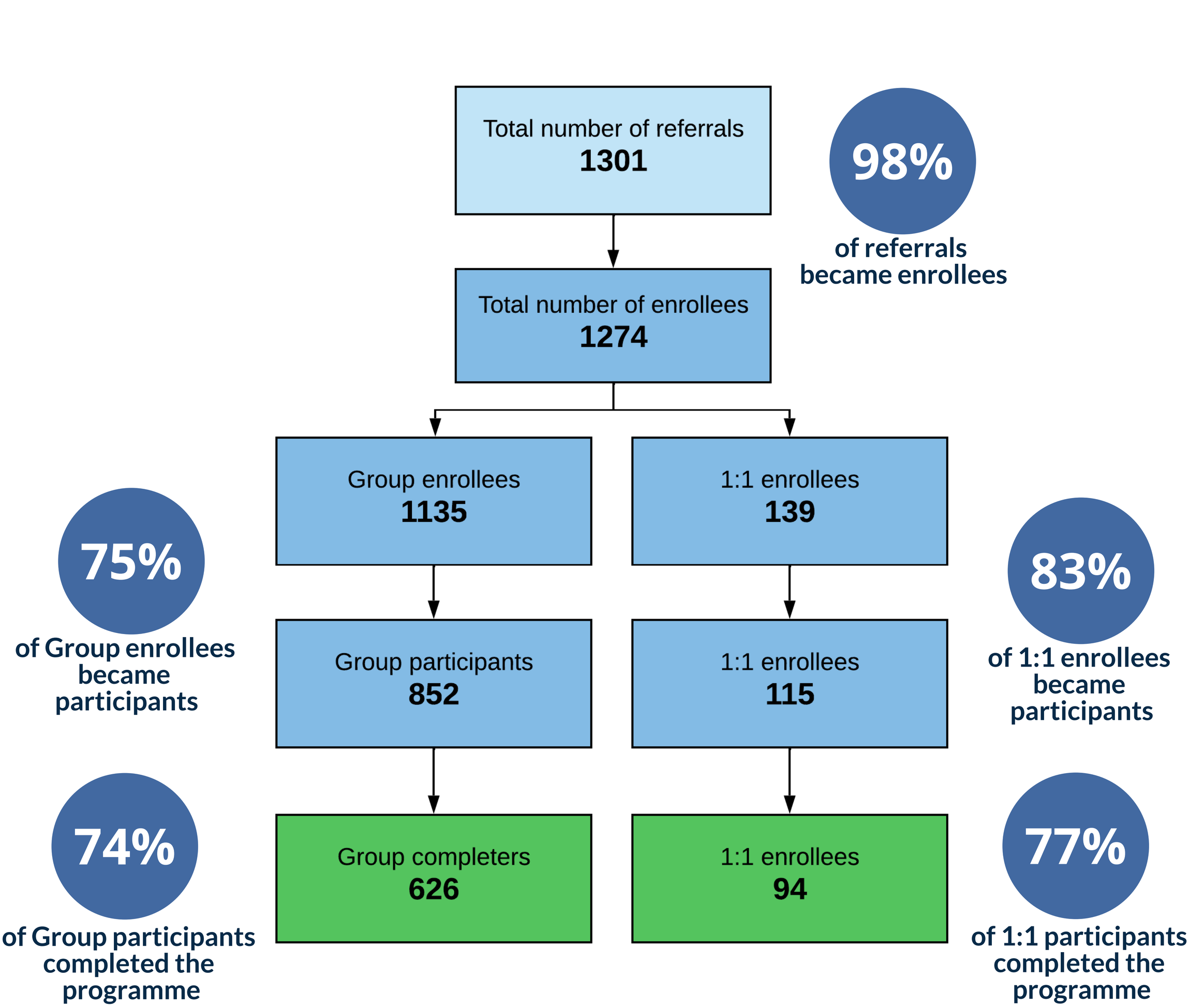


Figure 9. Participant flow through the project

Evaluation Findings

Implementation Evaluation

What was the ethnic background of families involved with the project?

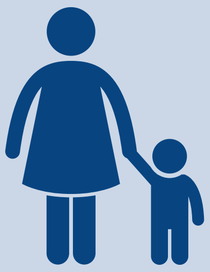
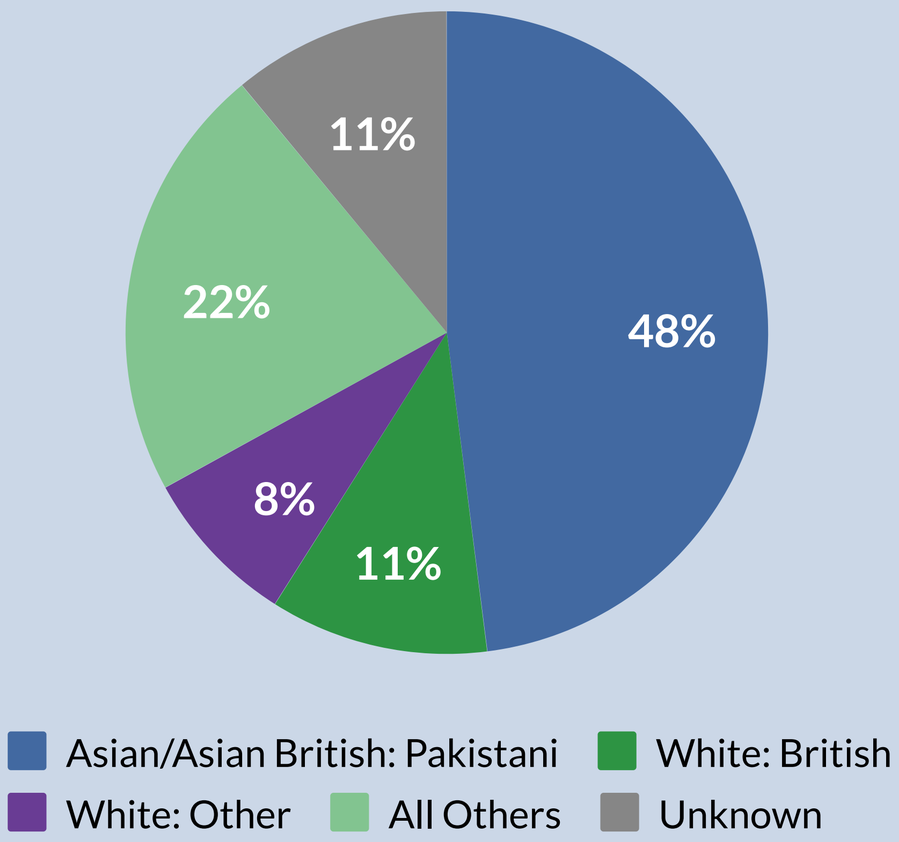


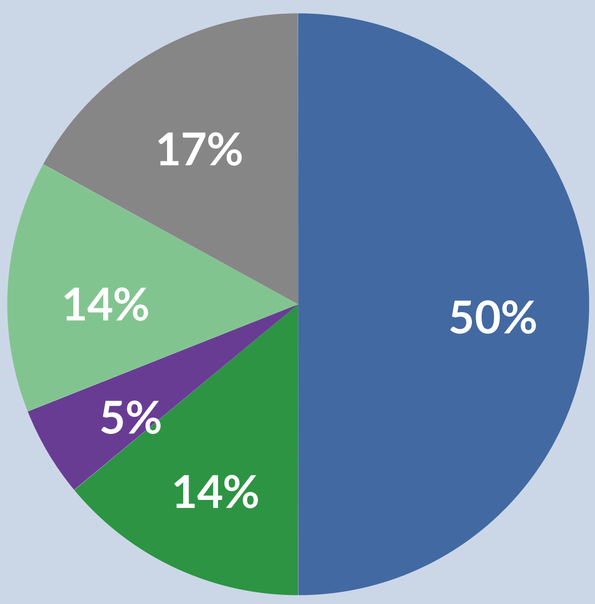
Figure 10. Ethnicity of mothers in BSB wards 2016 - 2024



A core goal of the HENRY project was to involve a representative group of families from the community. In the years between 2016 - 2024, 48% of mothers living in the Better Start Bradford area identified as Asian or Asian British Pakistani , 11% identified as White British, 8% identified as from an Other White background, and 22% of the population were from other ethnic backgrounds. Additionally, for 11% of mothers their ethnic background was unknown. Although not all participants were mothers, the vast majority were and this is why maternal ethnicity is used as the reference population. Note that ethnicity data is only available for the second and third contracts

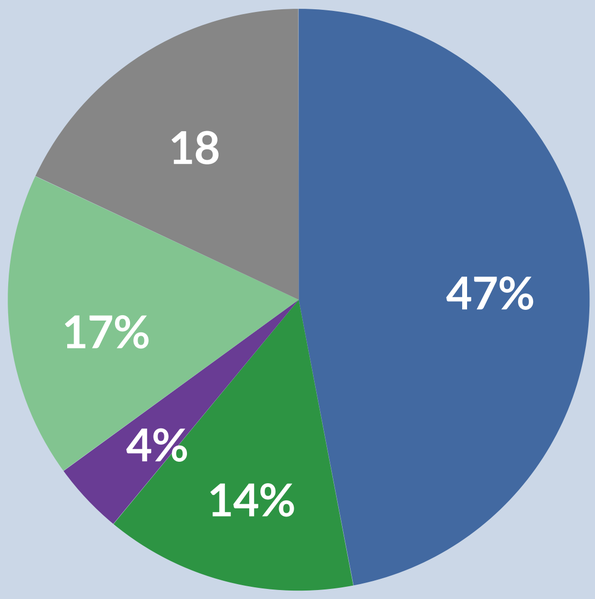
HENRY Group project reach

Figure 11. Group enrollment reach



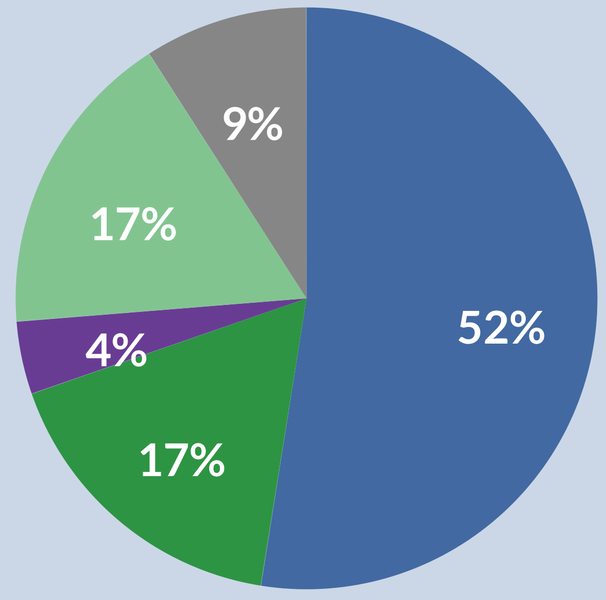
Across all years of delivery, 50% of enrollees were of Asian/Asian British Pakistani background, 14% of enrolless identified as White:British, and 5% identified as White: Other. Additionally, 14% of enrollees were from other ethnic backgrounds, and 17% were of unknown ethnicity.

Figure 12. Group participation reach



Of all participating parents, 47% were of Asian/Asian British Pakistani background, 14% identified as White:British, and 4% identified as White: Other. Additionally, 17% of participants were from other ethnic backgrounds, and 18% were of unknown ethnicity.

Figure 13. Group completion reach



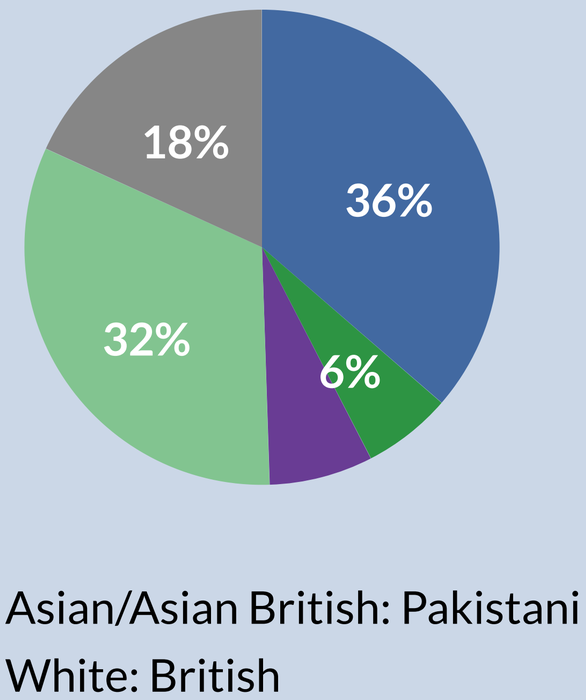
For participants that completed the project, 52% were of Asian/Asian British Pakistani background, 17% identified as White:British, and 4% identified as White: Other. Additionally, 17% of participants were from other ethnic backgrounds, and 9% were of unknown ethnicity.

Evaluation Findings

Implementation Evaluation

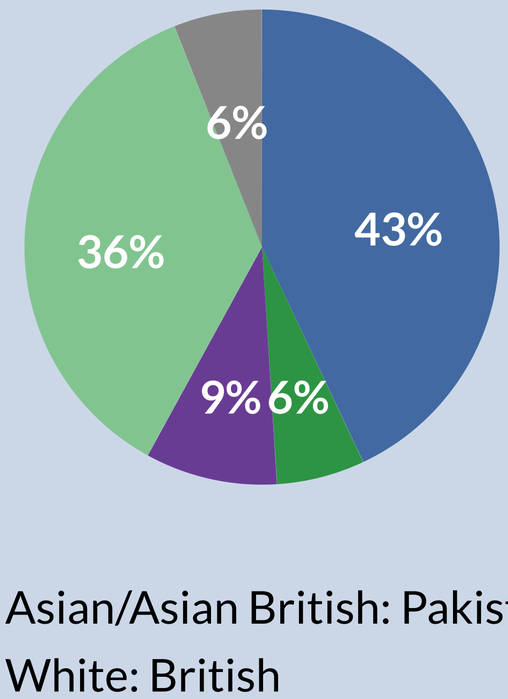
HENRY 1:1 project reach

Figure 14. 1:1 enrollment reach



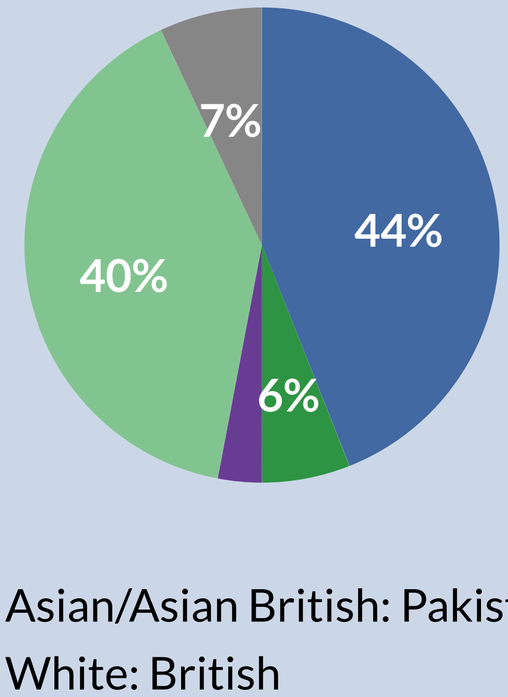
Across all years of delivery, 36% of enrollees were of Asian/Asian British Pakistani background, 6% of enrolless identified as White:British, and 7% identified as White: Other. Additionally, 32% of enrollees were from other ethnic backgrounds, and 18% were of unknown ethnicity.

Figure 15. 1:1 participation reach



Of all participating parents, 43% were of Asian/Asian British Pakistani background, 6% identified as White:British, and 9% identified as White: Other. Additionally, 36% of participants were from other ethnic backgrounds, and 6% were of unknown ethnicity.

Figure 16. 1:1 completion reach



For participants that completed the project, 44% were of Asian/Asian British Pakistani background, 6% identified as White:British, and 3% identified as White: Other. Additionally, 40% of participants were from other ethnic backgrounds, and 7% were of unknown ethnicity.

Group reach targets

98% of target

Asian: Asian British Pakistani

127% of target

White British

50% of target

White Other

The HENRY project had reach targets for a representative proportion of participants from each of the three main ethnic groups. A representative sample would consist of 48% Asian: Asian British Pakistani participants, 11% White British participants, and 8% from an Other White background.

For the Group programme, participants were representative of the Asian: Asian British Pakistani population (98% of target), White British families were slightly overrepresented (127% of target), while parents from White Other backgrounds were underrepresented (50% of target).

For the 1:1 programme, parents from Asian: Asian British Pakistani backgrounds were well represented (91% of target), White British participants were underrepresented (43% of target), while White Other parents were overrepresented (113% of the target). Given that the 1:1 delivery of the project aimed to make the intervention more accessible to families who would struggle with the group version, it is reasonable to expect a differences in the ethnic backgrounds of participants.

1:1 reach targets

91% of target

Asian: Asian British Pakistani

43% of target

White British

113% of target

White Other

Evaluation Findings

Implementation Evaluation

Who were the parents and caregivers that took part in the project?

What languages did parents/carers speak?

Families within the Better Start Bradford area speak a large range of languages in their homes, and one aim of the 1:1 version of the project was to support access for families with limited English. For the Group programme, 69% of participants reported speaking English as their primary language, and 18% spoke Urdu as their primary home language. Much smaller proportions of participants reported speaking Arabic (3%), Polish (2%), Punjabi (2%), Pashto (2%), Romanian (3%), and any other language (3%).

This was very different to the 1:1 delivery of the project, where only 34% of participants reported speaking English as their primary language, and 16% of participants spoke Urdu primarily. Additionally, 13% of participants spoke Punjabi, 9% spoke Bengali, 8% spoke Arabic, and 20% spoke all other languages. This demonstrates that the 1:1 delivery of the project was clearly utilised to engage a diverse range of families who may otherwise have struggled to access the Group delivery of the project.

Figure 17. Primary languages of Group participants

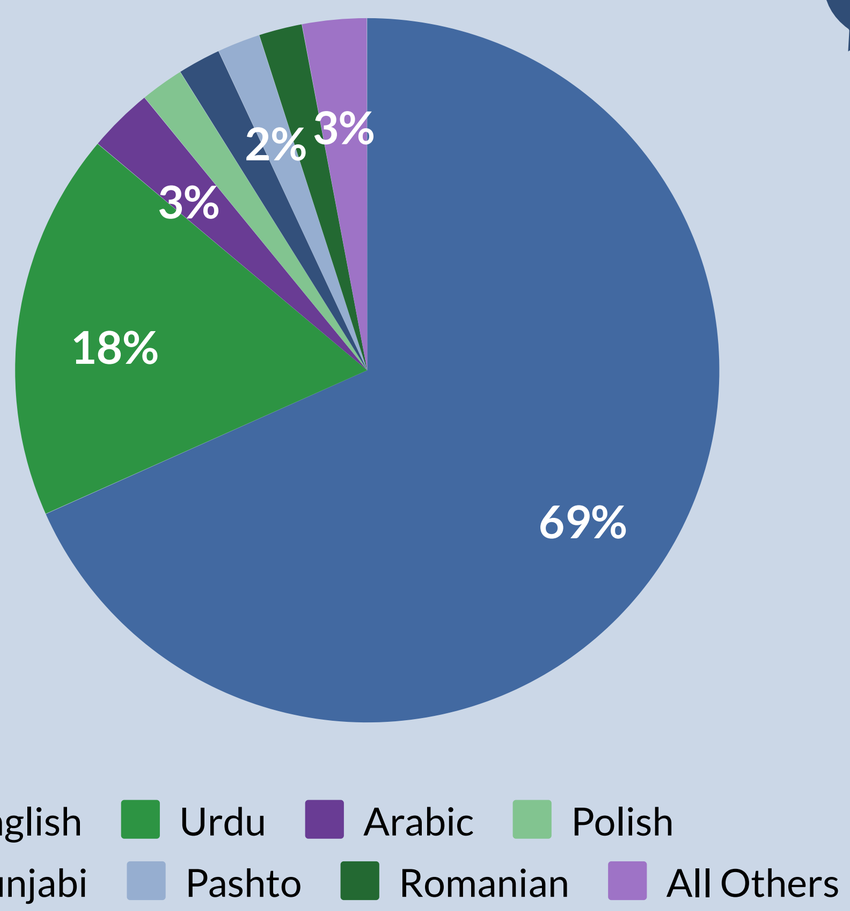
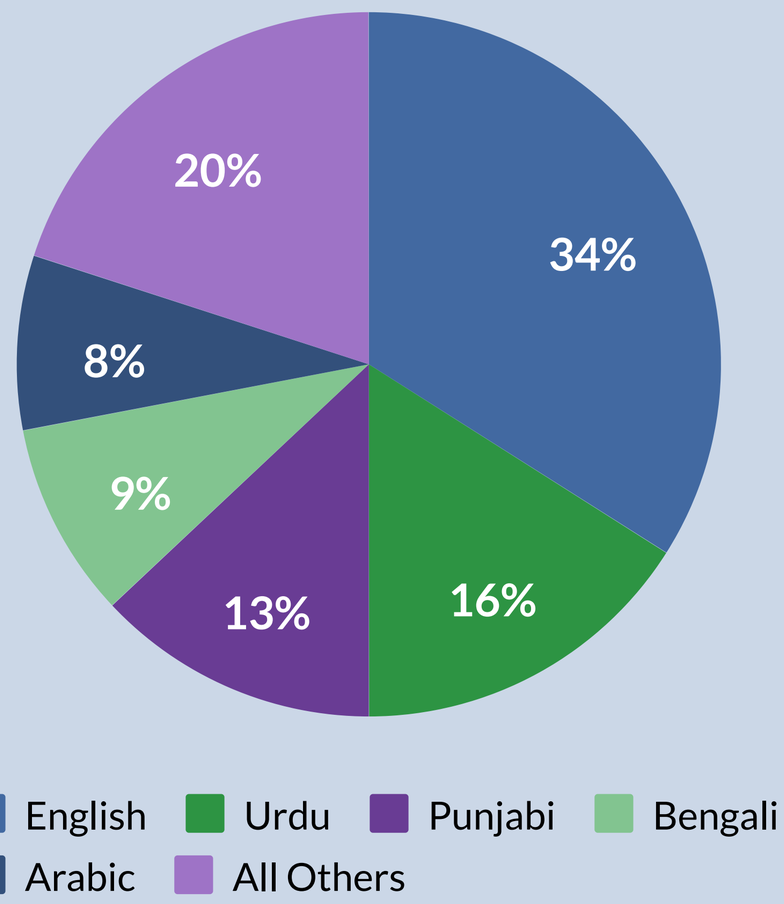
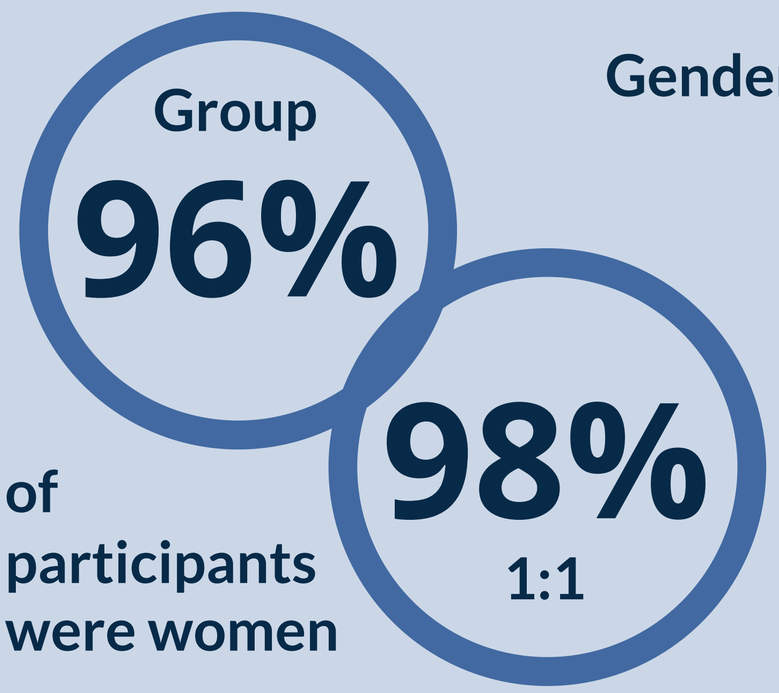


Figure 18. Primary languages of 1:1 participants



Gender and Relationship to Child



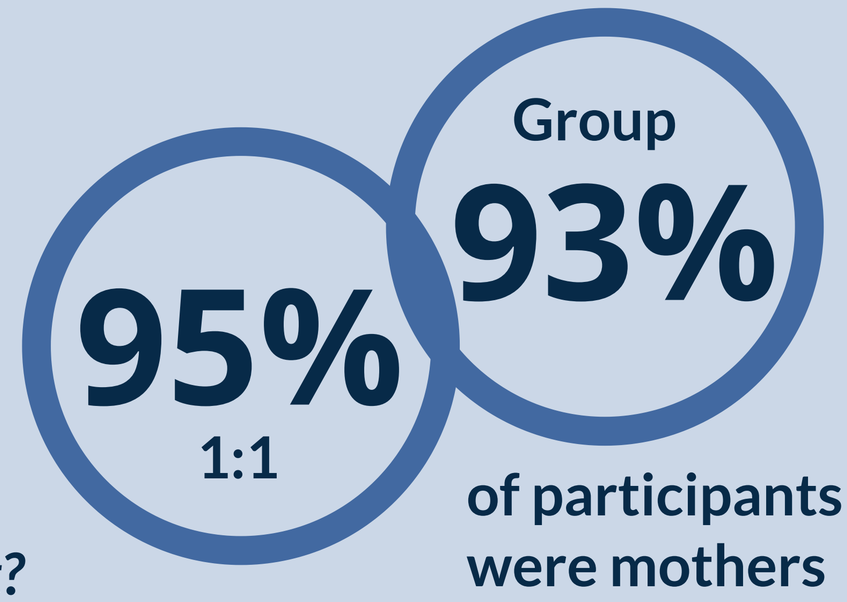
Information on the gender of participants and the relationship between the HENRY participant and the child beneficiary was available for 58% of Group participants and 70% of 1:1 participants.

For both the Group and 1:1 delivery of the project, the vast majority of participants were women; 96% for Group delivery, and 98% for 1:1 delivery.

Evaluation Findings

Implementation Evaluation

In terms of the relationship between participants and child beneficiaries, for the Group delivery 93% of participants were mothers, and in the 1:1 delivery 95% of participants were mothers.



Who were the children that benefitted from the project?

In total, 1152 unique children were identified as having a parent or carer who attended the HENRY Group or 1:1 programme; 928 unique child beneficiaries of the Group programme, and 158 unique beneficiaries of the 1:1 programme.

Average age of child beneficiaries by contract

Overall average age of child beneficiaries

Overall, the average age of child beneficiaries of the project was 35 months (2 years 11 months). This represents an age range from 0 months - 157 months (13 years 1 month). However, the average age of beneficiaries decreased across the three contract periods, from 44 months in the first contract, 35 months in the second contract, and 25 months in the third contract. It is unclear why this happened, but could reflect changes in how parents were recruited into the project.

Evaluation Findings

Implementation Evaluation

How many Group programmes did the project offer?

Across the evaluation period it was anticipated that the project would deliver a total of 160 Group programmes; in reality the project was able to deliver 117 programmes. This represents 73% of the target number of programmes delivered. Performance against annual targets is shown in Figure 19.

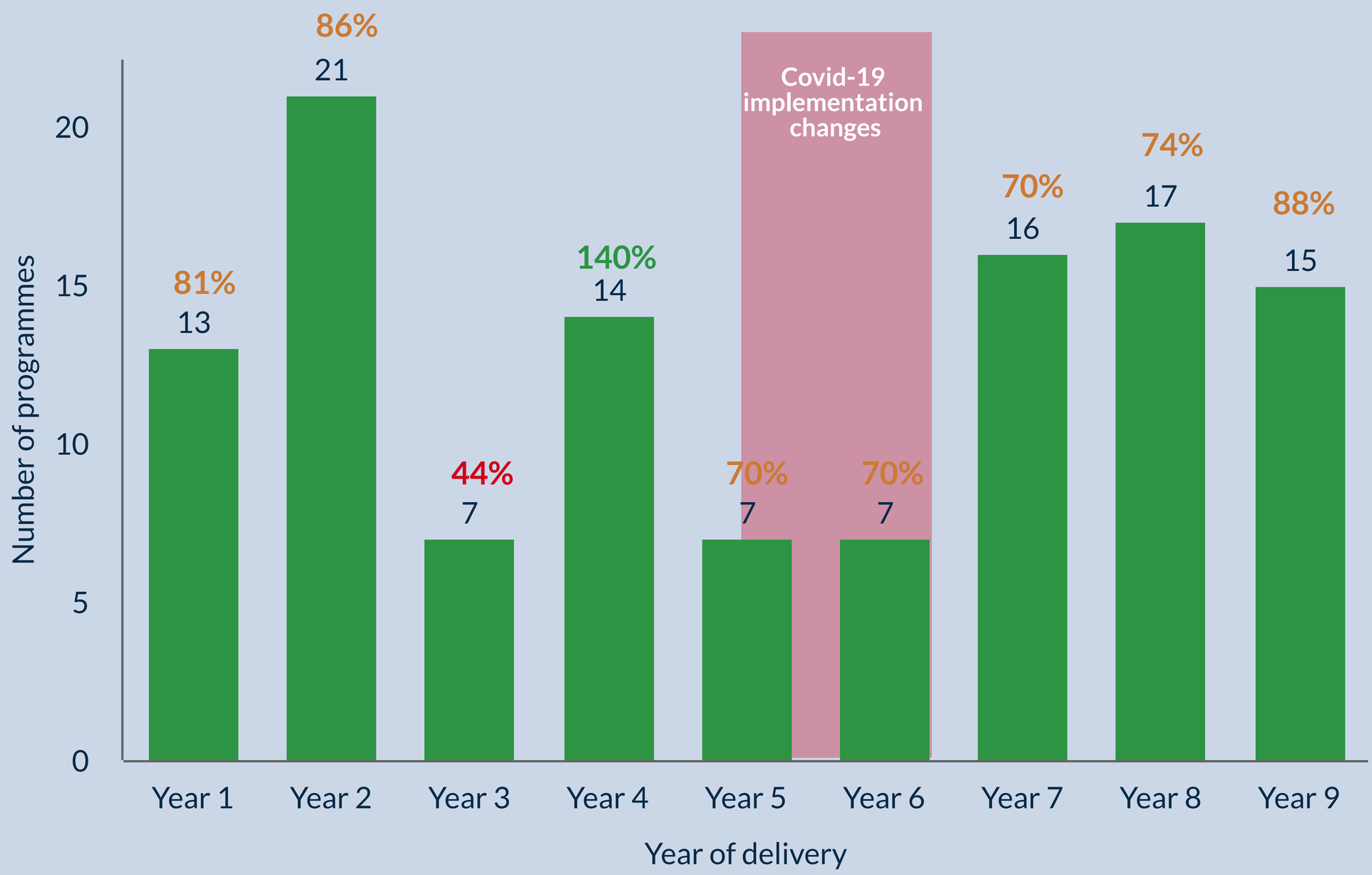


Figure 19. Number of Group programmes delivered annually

73%

of anticipated Group programmes were delivered

Cancelled programmes

In addition to the 117 group programmes that were delivered, another 21 group programmes were scheduled but then cancelled. The reasons for these cancelled sessions were either low enrollment numbers, a lack of facilitators or staff, or a combination of both of these issues. This means that 15% of planned courses were cancelled.

Evaluation Findings

Implementation Evaluation

Practitioner training

An central element of the HENRY project was to provide training to professionals and voluntary community sector staff who interact with children. This included three main training offers; Core Skills Training, A Healthy Start in Childcare, and Group Facilitation Skills Training.

Core Skills Training - This training was for health and early years professionals and provides information on healthy choices for young children. Targets for this training ranged from a maximum target of 48 practitioners trained annually in the first contract (y1-y3), 8-16 practitioners trained annually in the second contract (y4-y6), and 10 practitioners trained annually in the third contract (y7-y9). Aside from year 6 which was affected by Covid-19, training figures ranged between 10 (y9) to 34 (y1) practitioners trained annually. Overall, the total number of practitioners trained represents **76% of the lower target** (8 practitioners in y4-y6).

150
practitioners trained in *Core Skills*

A Healthy Start in Childcare Training - This training was provided to childcare settings and was meant to complement existing food policy. Targets for this training ranged from a maximum target of 48-60 practitioners trained annually in the first contract (y1-y3), 8-16 practitioners trained annually in the second contract (y4-y6), and 10 practitioners trained annually in the third contract (y7-y9). Aside from y6, training figures ranged from less than 5 (y9) to 49 (y2) practitioners trained annually. Overall, the total number of practitioners trained represents **62% of the lower target** (8 practitioners in y4-y6).

over 130
practitioners trained in *A Healthy Start in Childcare*

Group Facilitation Skills Training - This training was provided to enable staff to deliver the HENRY's group programme for families. Targets for this training ranged from a maximum target of 12 practitioners trained annually in the first and second contracts (y1-y6), and 10 practitioners trained annually in the third contract (y7-y9). Training figures ranged from less than 5 (y3, y6) to 19 (y1) practitioners trained annually. Overall, the total number of practitioners trained represents **64% of the total target**.

over 65
practitioners trained in *Group Facilitation Skills*

Evaluation Findings

Before & After Evaluation

Parents and caregivers complete questionnaires at the start and end of group and 1:1 programmes and answer questions relating to their confidence as a parent, family mealtimes, family diet and physical activity and boundaries and cooperation at home. Participating parents and caregivers completed both pre and post questionnaires and consented to share their data with us during this evaluation period. The findings presented are based on questionnaire data from participants of the group (Pre n=234, Post n=224) and 1:1 programme (Pre n=46, Post n=41) between 2016 and 2021. Changes made to the questionnaire by HENRY during the third contract meant it was not possible to include this data in the analysis.

A 'before and after' evaluation tells us about changes that have taken place from the time before families took part in a project, to immediately after. However it does not tell us whether those changes are caused by the project as there is no control group for comparison. The findings presented here should not be taken as an indication of the effectiveness of HENRY. Please note only statistically significant results are reported here and more detailed results can be requested.

Group Programme

Based on the data from parents and caregivers pre (n=234) and post (n=224) programme, statistically significant improvements were found at the end of the group programme in the following areas:

Parenting : Parents and caregivers were asked four questions about how confident they feel as a parent.

Parents and caregivers reported that their confidence, how supported they feel and their happiness levels had increased at the end of the programme. This was also found for how well parents felt they generally set boundaries and encouraged cooperation in the following areas:

Meal and Snack Times

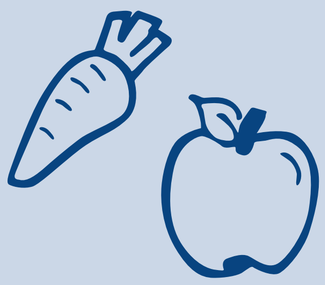
Bedtimes

TV and computer

Active Play

Family Mealtimes : Parents and caregivers were asked six questions about their family mealtime habits.

Parents and caregivers reported sitting down as a family to eat meals more frequently and choosing to eat healthy meals more frequently.

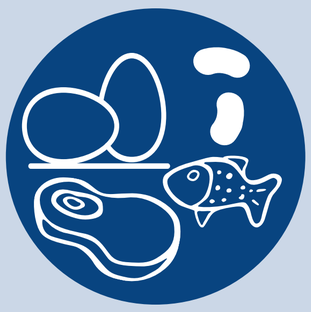


Parents and caregivers reported having the TV on at mealtimes less frequently and having takeaway food less frequently.

Evaluation Findings

Before & After Evaluation

Family Diet: Parents and caregivers were asked about their own and their child's diet

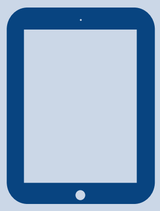


Parents showed significant differences in the average times a day they ate fruit and vegetables; bread, rice, potatoes and pasta and meat, fish, eggs and beans. There was also a reduction in the number of high fat and sugary snacks and sugar-sweetened drinks consumed per day.

Children showed significant differences across all outcomes. There were differences following the programme in the average times a day they ate fruit and vegetables; bread, rice, potatoes; pasta and meat, fish, eggs and beans; milk and dairy and water drank. There was also a difference in the number of high fat and sugary snacks and sugar-sweetened drinks consumed per day.

Family Physical Activity: Parents and caregivers were asked about their own and child's activity levels

Parents and caregivers were asked to share the number of hours they and their children exercise or stay active each day. Following the programme there was an improvements to activity levels for children and adults.



Parents and caregivers reported reductions in screen time for children aged 2-5 years at the end of the programme.

1:1 Programme

Based on the data from parents and caregivers pre (n=46) and post (n=41) programme, statistically significant improvements were found at the end of the group programme in the following areas:

Parenting : Parents and caregivers were asked four questions about how confident they feel as a parent.

Parents and caregivers reported that their confidence as a parent had increased at the end of the programme. They also reported feeling more supported and less isolated. Positive outcomes were also reported for how parents felt they generally set boundaries and encourage cooperation in the following areas

Meal and Snack Times

Bedtimes

TV and computer

Parents also report having more time for themselves at the end of the programme

Evaluation Findings

Before & After Evaluation

Family Mealtimes : Parents and caregivers were asked six questions about their family mealtime habits.

Parents and caregivers reported having the TV on at mealtimes less frequently and sitting down as a family to eat meals more frequently.

Family Diet: Parents and caregivers were asked about their own and their child's diet

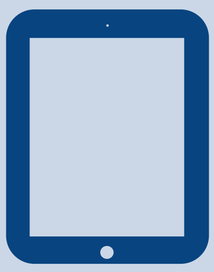
Parents showed statistically significant improvements to average the fruit and

vegetable; bread, rice, potatoes and pasta and water intake after programme completion.

Children showed significant differences in the majority of outcomes.

There were differences following the programme in the average times a day they ate fruit and vegetables; bread, rice, potatoes; pasta and meat, fish, eggs and beans; milk and dairy and water consumed. There was also a significant change in the number of high fat and sugary snacks eaten per day.

Family Physical Activity: Parents and caregivers were asked about their own and child's activity levels



They were also asked about how much screen time their child has each day (aged under 2 and 2-5yrs).

Parents reported significant reduction in screen time for children under 2 years at the end of the programme.

Evaluation Findings

Conclusions

Over the nine years of delivery as part of Better Start Bradford, the *HENRY: Healthy Families Right From the Start* project was offered to over 1300 families, with 98% going on to enrol; 1135 on the Group programme and 139 on the 1:1 format. Transition from enrollee to participant was high for both programmes (75% group and 83% 1:1). Rates of completion were also high exceeding ambitious targets for the 1:1 programme, with 77% of participants completing. For the group programme completion rates were just below the ambitious target of 75% (74%). These figures suggest the project is very effective at keeping families engaged once they are in the programme, indicating it is enjoyed and valued by participants.

Reach progression criteria for the project set the target that the project would recruit a representative sample of families for both the Group and 1:1 delivery of the service. While the project recruited a representative proportion of families from Asian: Asian British Pakistani backgrounds to both delivery formats, White British families were somewhat over-represented in the Group delivery, while White Other families were over-represented in the 1:1 delivery. However, alongside the demographic data on families' primary languages, this ethnicity data actually seemed to show that the Group and 1:1 versions of the project were serving different groups of the eligible population. This should be considered a strength of the programme; the ability of the service to provide interpreters and other support enabled families to engage with the 1:1 service who may have been unable to access the Group provision. This may also suggest that the initial enrollment of families worked well to ensure that families were directed to the version of the service that best suits their needs.

The project was primarily accessed by women, and these women were predominantly the mothers of the child beneficiaries of the project. This is in keeping with the expectations of the project, and is similar for other projects with similar delivery formats.

Results from the before and after evaluation indicate significant improvements in parental confidence at the end of both programmes as well as positive changes in family mealtime behaviours, carer and child diet, carer and child physical activity levels, and child screen time. Of particular note are increases in fruit and vegetable consumption, an reductions in high fat and sugar snacks, and sugary drinks consumption. While it is not possible to make conclusions about programme effectiveness based on these findings (because a lack of control group), these results are promising and do indicate participation in HENRY may support families to move towards healthier lifestyles.

A complementary component of the project was to provide training for practitioners working with young children in the community. For the project's *Core Skills* training offer, they managed to train 76% of the target figure, for the *A Healthy Start in Childcare* training offer they managed to train 62% of the target figure, and for the *Group Facilitation Skills* training offer 64% of the target figure. Although these numbers may be somewhat lower than hoped, they still represent a very considerable number of practitioners in the community with increased understanding of supporting very young children's healthy development.

Evidence for HENRY

Evidence Review and Rating

Over the past nine years of HENRY delivery in the BSB area, there have been a small number of evaluations of HENRY services for children under 5 across the UK. An evaluation of a volunteer-led version of *Healthy Families Right from the Start* based in London from 2021 showed that families reported a range of improved outcomes after attending the service, including parenting efficacy, setting limits, emotional wellbeing, as well as family and child eating behaviours, food purchasing and preparation, and fruit and vegetable intake (Howlett et al., 2021). Parents also reported that the programme supported their relationship skills and they felt the programme was non-judgmental and accessible. Another evaluation of the HENRY *Starting Solids* workshop showed that parents felt the session provided good preparation for starting solid foods, supported parents to wait until at least 6 months to begin weaning, to ensure that breast and/or formula milk remained the main food source for children beyond six months of age, and to offer solid foods in a responsive way. Parents reported that sessions felt supportive, non-judgemental, and informative (Brown et al., 2022).

Most notably, Prof Maria Bryant and colleagues carried out a cluster-randomised controlled feasibility study of HENRY (Bryant et al., 2021). The specific aim of this study was to consider whether a full-scale randomised controlled trial to evaluate the impact of HENRY on child BMI would be possible, and the feasibility study concluded that it would be possible with methodological changes to support the larger trial. Although it is important to interpret outcome data from a feasibility study with caution, there was some initial evidence of promise suggesting that participating in HENRY had a positive impact on children's BMI. The full-scale trial has now begun (Bryant et al., 2023), and has a scheduled completion date of 2027. Importantly, this trial means we know that strong evidence on the effectiveness of the programme will be available in the foreseeable future.

Although the evidence base from HENRY is still listed as Level 2 in the EIF Guidebook, this likely does not take into account the most recent evaluations and research on the service. The BSBIH's current assessment is that the feasibility study and other evaluation evidence puts the project at an evidence level of 2+, with ongoing research that will determine whether the project reaches Level 3.

Overall, this demonstrates that HENRY is an evidence-informed programme with a developing evidence base. Although other programmes to tackle early childhood overweight and obesity do exist, few if any are as well developed with ongoing effectiveness evaluation research as HENRY.

Level 2+

Recommendations

Recommendations for Practice

There remains a need to address the precursors and early instances of overweight and obesity in the BSB community as well as the wider Bradford district. Although other programmes exist that focus on preventing overweight and obesity in childhood, few if any of these are as well developed and embedded as the HENRY programme. This report demonstrates that the HENRY project has managed to navigate an incredibly challenging time in preventative intervention work, and has engaged with a large number of families in the BSB community. There is also evidence that the different delivery options (Group; 1:1) are being utilised to extend the reach of the project, which is a particularly important consideration for the BSB community. For these reasons, the BSBIH recommends the following:

- Continue to explore options for how this service could be delivered in the district. While there is strongest evidence for the *HENRY: Healthy Families Right From the Start* programme, recent experiences have shown that the *Starting Solids* workshops are popular, and an evaluation elsewhere showed these workshops supported complementary feeding practices. For this reason, it is worth considering how a holistic service could be implemented that supports families to develop healthy feeding and eating habits right from when children begin weaning.
- If the project were to continue, it would be useful to carefully consider the referrals pathways into the project. In the most recent contract, many referrals have come from other BSB projects, and it would be vital to consider other referrals sources in the absence of BSB.
- The 1:1 version of the programme allows families to engage with the programme who may otherwise not be able to, and as such future versions of the project should aim to continue this component of the programme.
- Consider whether training and other supports for childcare settings would be possible. Many children spend significant amounts of time in early years education and care settings, and this time represents a key opportunity to support their healthy relationship with food. However, staff turnover in settings means that many of the practitioners trained during this project may have left, and the cost of living crisis may be impacting on settings' ability to provide nutritionally balanced meals. Further training and support could be beneficial for children's wider environments.

Recommendations for Evaluation

The relatively consistent delivery of HENRY in the BSB area over the past nine years represents a unique opportunity to explore the impact of this service using routine data. The BSBIH is currently developing a protocol for a quasi-experimental evaluation of the HENRY service using data from the project along with routine child health outcome data. While the specifics of this evaluation are still in development, the overall aim of the evaluation would be to consider whether BiBBS children whose parents attended HENRY had significantly lower body mass indexes (BMIs) at ages 2 or 5 years, as compared to similar children who did not attend the project. It is encouraging that the data from the implementation evaluation reported here suggests that there is likely to be a sufficient sample of families available to the evaluation to allow for the necessary analyses. As such, the BSBIH's recommendation is that this evaluation move forward. However, it should be noted that the younger average age of the children in the final years of service delivery suggests that this evaluation will not be available until approximately 2028 when a sufficient number of the child beneficiaries have reached the age of 5 and National Child Measurement Programme data is available for them.